Substance Use Disorder Treatment

CareOregon

Authorization Request

Please complete all fields below as indicated, select the appropriate level of care, and attach relevant clinical documentation. Please type directly onto the form and please make sure the request form is complete and legible. Providers must submit all authorization request forms via Connect, CareOregon's online portal (accessible via the For Providers section of our website), or send by fax to 503-416-4727.

Date of request: _____/_____/_____

Member Information

Last name: _____ First name: _____ MI: _____

DOB: _____/_____/_____Member OHP ID#: _____

Provider Information

Delivering Provider		**Referring Provider**	
Contact person:		Contact person:	
Contact phone:		Contact phone:	
Contact email:		Contact email:	
Contact fax:		Contact fax:	

Admit date: _____ End date (if applicable): _____

DSM-5 substance use disorder diagnosis: _____

DSM-5 substance use disorder diagnosis severity specifier (e.g., mild, moderate, severe): _____

DSM-5 covered mental health diagnosis on the prioritized list (required for dual diagnosis treatment): _____

_____

Continued >>

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Select level of care

- ◯ Assessment
- ◯ Medication Assisted Treatment OTP
- ◯ General Outpatient
- ◯ Intensive Outpatient
- ◯ Day Treatment
- ◯ Residential
- ◯ Withdrawal Management

Additional Comments